



Olympia Neurology PLLC

525 Lilly Road, NE
Olympia, WA 98506

Please take time to fill in all the blanks

Patients Full Name: _____

Social Security #: _____ Date of Birth: _____

Street Address: _____

PO Box #: _____ City: _____ State: _____ Zipcode: _____

Home Phone #: _____ Work Phone #: _____

Marital Status: (S M WD D Sep) Male / Female Employer: _____

Student: Yes / No Name of Current School, College, University: _____

Name of Spouse: _____ or Parent (if pt. is a child): _____

Spouse / Parent Date of Birth: _____ Spouse or Parent Work Phone: _____

Emergency Contact Name: _____ Phone Number: _____

Name of Referring Physician : _____

Name of Primary Care Physician : _____

Primary Insurance Plan: _____ Group Number: _____ ID Number: _____

Subscriber's Name: _____ Subscriber's Employer: _____

Secondary Insurance Plan: _____ Group Number: _____ ID Number: _____

Subscriber's Name: _____ Subscriber's Employer: _____

Is this visit covered under L & I? Yes / No

Name of Industrial Insurance Company: _____

Address of Industrial Carrier _____

Date of Injury: _____ Claim Number: _____ Injured Body Part: _____

Employer at time of injury: _____ In which state were you injured? _____

Is today's visit related to a motor vehicle accident? Yes / No

Motor vehicle insurance responsible: _____

FINANCIAL AUTHORIZATION

I authorize medical care for _____ . I hereby authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for payment of all services according to Olympia Neurology policy, regardless of any pending insurance claims. I authorize the physician to release any information necessary to the insurance company (ies) as listed for the processing of claims.

I understand that my express consent is required for the medical provider to release any information in relation to the diagnosis and/or treatment of HIV (Aids Virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection with any of the above listed conditions, you are specifically authorized to release to the listed insurances all information or medical records relating to the diagnosis, testing or treatment. *

Patient Signature: _____ Date: _____

If a minor, by parent or guardian: _____ Date: _____

*If the patient has reached his/her 14th birthday, ONLY the patient may authorize disclosure relating to sexually transmitted disease.

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information necessary for this or a related Medicare / Medigap / other insurance claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

Regulations pertaining to Medicare assignment of benefits apply. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: _____ Date: _____

CONFIRMATION OF RECEIPT OF PRIVACY NOTICE

Yes, I have received a copy of Olympia Neurology's Privacy Notice as required by the Federal HIPAA Standard.

Signature: _____ Date: _____